Testimony to the Kansas Health Policy Authority

July 27, 2006

Presented by:

Walter Hill, Executive Director
High Plains Mental Health Center

Madam Chair, Committee Members, and Director Nielsen, thank you for your travel to rural Kansas as part of your listening tour. I have attached detailed testimony and information prepared by the Association of Community Mental Health Centers of Kansas and submitted

at previous listening tour locations about statewide issues and our statewide system of integrated mental health service delivery.

Kansas is unique in having an integrated, locally governed, county based public mental health system that covers all 105 counties in Kansas. High Plains Mental Health provides a regional, consolidated system of mental health services in the 20 counties of Northwest Kansas, serving as the local public mental health department for those counties. High Plains provides a range of services with 200 staff including 4 psychiatrists and 3 psychiatric ARNPs, along with 50 Qualified Mental Health Professionals, and 50 Case Managers. Last year we served 5,000 patients in this area that has a population of 114,000 residents, and assisted countless others in the lives of those 5,000 patients. I have attached a copy of the High Plains 2005 Annual Report.

Mental health is a unique area of health care, because of our core bio-psycho-social model, that integrates health care and certain social services. The CMHC system in Kansas has been a vital and effective method of braiding health care and social services dollars, state and federal and private, to accomplish goals of a variety of stakeholders at the state level, in healthcare, social services, corrections, etc. We look forward to the continued effective integration of health care policy and social services policy that has allowed us to effectively serve the whole of Kansas, and be the focal point locally to help us all serve within the limited resources of the immediate future.

Our mental health system in Kansas is unique in that we have essentially managed care and dollars for many years. The public mental health system in Kansas serves all individuals regardless of ability to pay. High Plains pulls together various funding streams to be able to provide services regardless of one's ability to pay, with a fixed subsidy funding for the uninsured and with one half of our Medicaid services being capped. We look forward to the opportunity to take the strengths of our current system to assist with the upcoming changes in the Kansas Medicaid system.

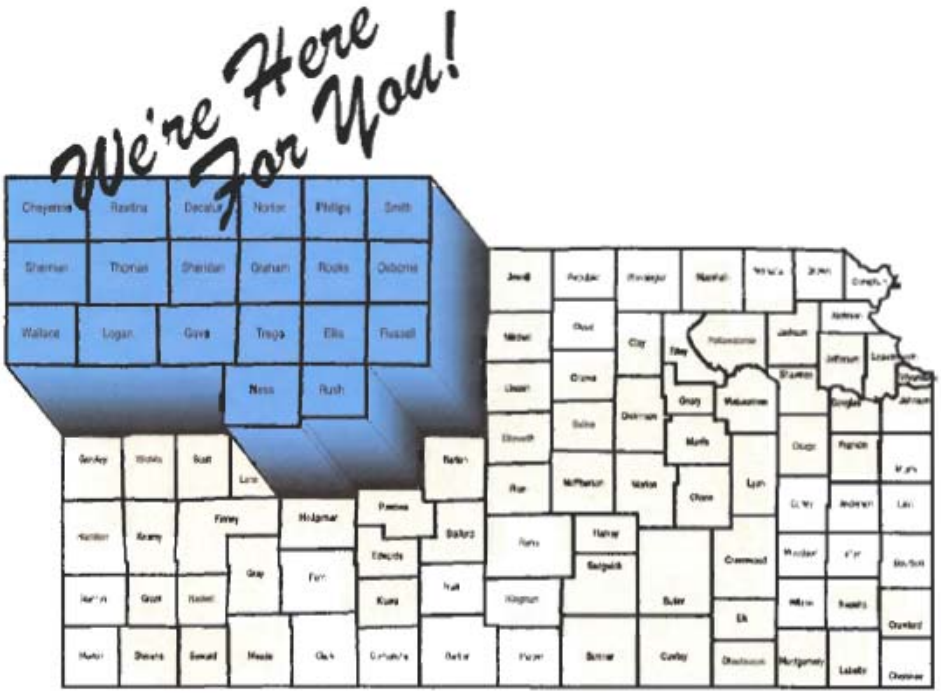
We face many challenges in rural and frontier mental health service delivery, but have found innovative ways to deliver cost effective care, especially through the use of our telemedicine system that helps us allow the equivalent of one physician's time to be available to see patients rather than spending that time in traveling….while allowing faster, closer access to patients to specialty psychiatric care. We are challenged by staffing issues, and this is likely to become a greater and greater issue in Kansas rural and frontier mental health services. Our third great challenge is the development of a system of integrated care for our growing elder population to meet their mental health needs in the next 20 years.

Thank you for the opportunity to speak to you today. I would be glad to make myself available at any time to you for specific additional information, questions or input.

HIGH PLAINS

A Licensed Community Mental Health Center

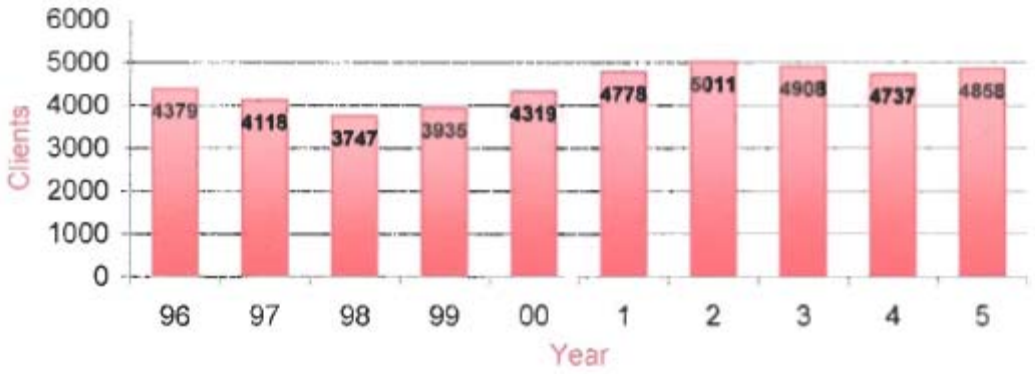
2005 Annual Report



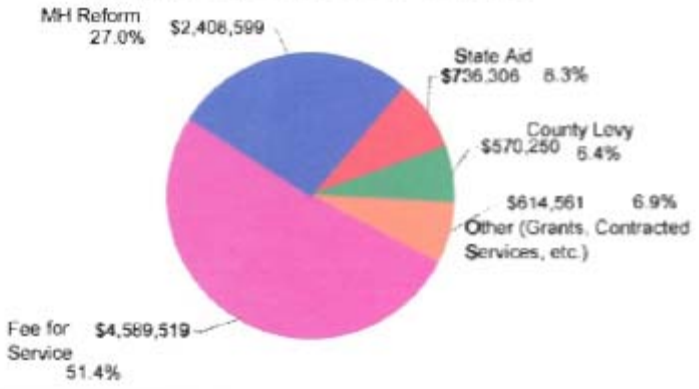
Serving Northwest Kansas since 1964

HIGH PLAINS MENTAL HEALTH CENTER
2005 ANNUAL REPORT

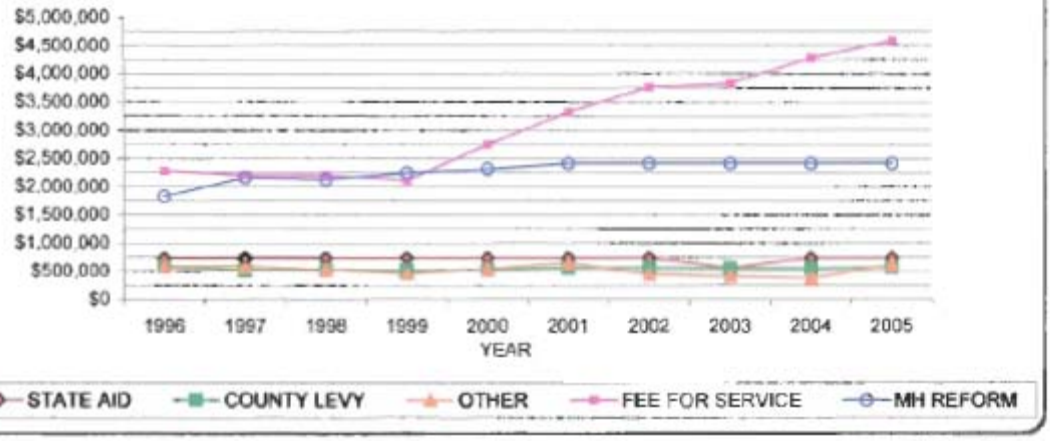
ANNUAL COMPARISON OF CLIENTS SERVED



2005 REVENUE AS % OF BUDGET



SOURCES OF REVENUE



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2005 ANNUAL REPORT

4,858 CLIENTS SERVED

791 Severe and Persistent Mental Illness --- 1,468 Serious Emotional Disturbance

Age Range by Gender				
Range	Number Served	Males	Females	% of Total
0 years - 9 years	387	233	154	7.97%
10 years - 19 years	1191	654	537	24.52%
20 years - 24 years	463	241	222	9.53%
25 years - 59 years	2439	1102	1337	50.21%
60 years - 64 years	111	45	66	2.28%
65 years & +	267	107	160	5.50%
Total	4858	2382	2476	
Total < 18	1340	765	575	

Annual Family Income		
Range	Number Treated	% of Total
$ 0 to $ 9,999	1557	35.96%
$10,000 to $14,999	554	12.79%
$15,000 to $24,999	635	14.67%
$25,000 to $34,999	371	8.57%
$35,000 to $49,999	299	6.91%
$50,000 to $74,999	167	3.86%
$75,000 and up	72	1.66%
Unreported	675	15.59%
Total	4330	

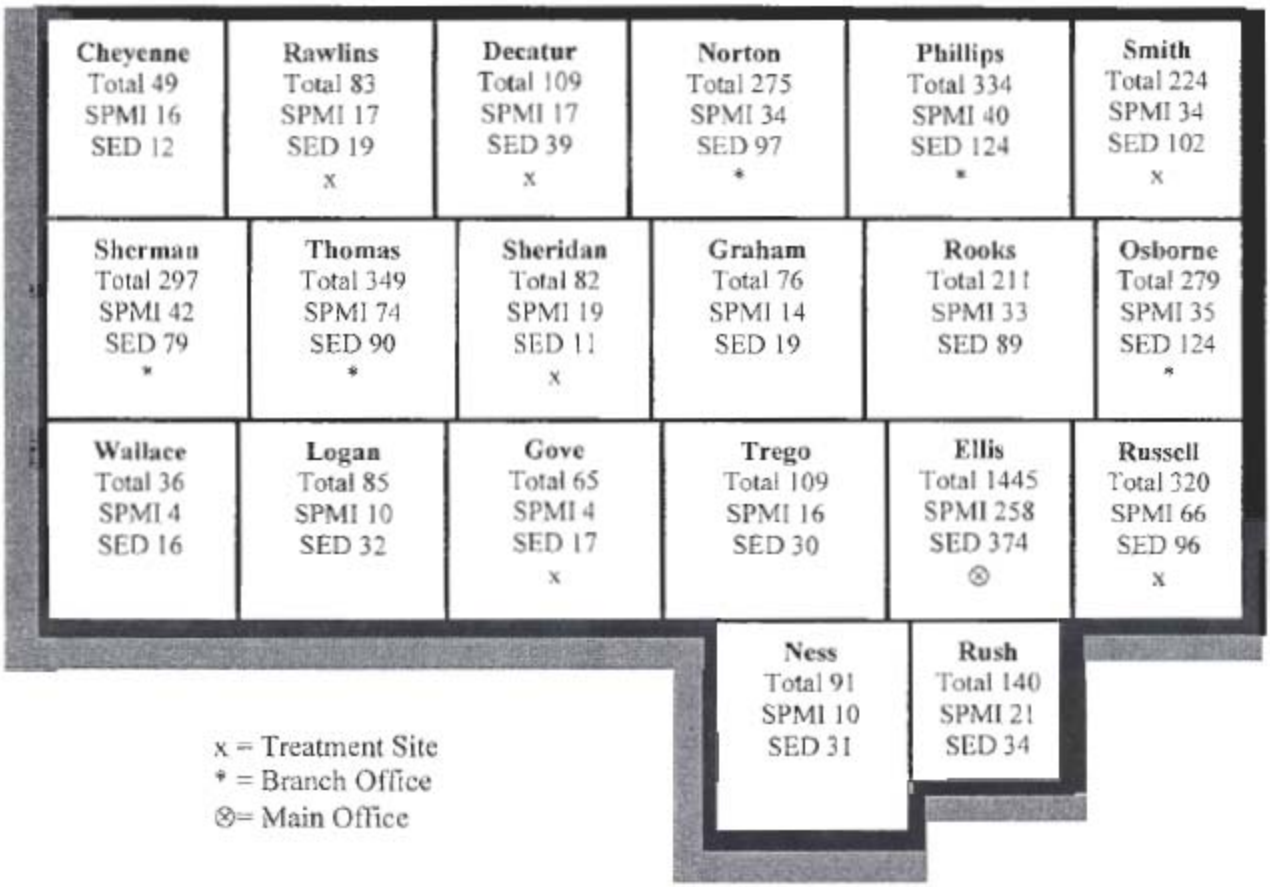
Primary Diagnosis (most recent)	Number Treated	% of Total
Mood Disorders	1976	45.64%
Disorders Usually First Evident in Infancy, Childhood, or Adolescence	770	17.78%
Anxiety Disorders	499	11.52%
Adjustment Disorders	313	7.23%
Other Conditions That May Be A Focus of Clinical Attention	266	6.14%
Schizophrenia and Other Psychotic Disorders	263	6.07%
Substance Related Disorders	89	2.06%
Impulse Control Disorders Not Elsewhere Classified	62	1.43%
Personality Disorders	37	0.85%
Sexual and Gender Identity Disorders	16	0.37%
Eating Disorders	13	0.30%
Delirium, Dementia, and Amnestic and Other Cognitive Disorders	10	0.23%
Mental Disorders Due to a General Medical Condition	7	0.16%
Somatoform Disorders	7	0.16%
Dissociative Disorders	1	0.02%
Sleep Disorders	1	0.02%
Total	4,330	

Sources of Referral to Center	Number of Referrals	
Self, Family, or Friend	1004	57.05%
Health Care Professional or Hospital	269	15.28%
Social or Community Agency	194	11.02%
Court, Law Enforcement, or Corrections	95	5.40%
Schools	64	3.64%
Other	45	2.56%
Mental Health Center	30	1.70%
Psychiatric Hospital	24	1.36%
Attorney	22	1.25%
Alcohol/Drug Abuse Agency	7	0.40%
Intermediate Care Facility	5	0.28%
Clergy	1	0.06%
Total	1760	

Psychoeducational Attendance	
Alcohol Information School	29
Adjusting to Divorce Class	13
Domestic Violence class	29
Anger Management Class	45
Grief Recovery	3

Consultation and Education	
Service Hours	1369
Travel Hours	299
Program Attendance	10579
Contacts	1896

HIGH PLAINS MENTAL HEALTH CENTER
2005 SERVED
Severe and Persistent Mental Illness (SPMI)
Serious Emotional Disturbance (SED)



Total Served = 4858 (Includes 199 Non Participating)
Total Severe and Persistent Mental Illness = 791 (Includes 27 Non Participating)
Total Serious Emotional Disturbance = 1468 (Includes 33 Non Participating)

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David Johnson, President
Michael J. Hammond, Executive Director

Testimony to the Kansas Health Policy Authority

July 27, 2006

Prepared by:

Michael J. Hammond, Executive Director
Association of Community Mental Health Centers of Kansas, Inc.

Madam Chair, members of the Kansas Health Policy Authority, and Dr. Nielson, my name is Mike Hammond, I am the Executive Director of the Association of Community Mental Health Centers of Kansas, Inc.

Earlier this week, you received a copy of our presentation packet which was given to you at the Kansas City stakeholder meeting. However, I know most of the comments delivered to you were from the local CMHC Director's perspective on health care challenges. Therefore, I would like to highlight some of the things included in our written comments here and then turn it over to Marilyn to provide you with some additional insights as a local provider.

The Association represents the 29 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week.

In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,000 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system of 29 licensed CMHCs form an integral part of the total mental health system in Kansas.

Recognizing your responsibility for the development of a statewide health policy agenda including health care, health promotion and health indicators, I hope you will find what I have to share with you today useful in fulfilling that responsibility.

I would like to begin by applauding efforts such as the Business Health Policy Committee, which is looking to increase the financial incentives available to small businesses when they decide to offer health insurance to employees; the Community Rx Kansas program, designed to provide low-income, uninsured Kansans access to affordable prescriptions; and Community Health Record, a piloted use of an electronic health record. These three examples represent an excellent start to begin addressing affordable health care for Kansans.

While we have had the opportunity for some limited dialogue with Connie Hubbell and Dr. Nielson in recent months around the topic of mental health and the Kansas public mental health system, this is the first opportunity we have had to appear before the entire Authority. Rather than consume my time before you today discussing the public mental health system, I have included with my testimony several attachments to serve as educational tools for you: Attachment A – CMHC Snapshot; Attachment B – Consumer Success Stories; Attachment C – Risk and Protective Factors; and Attachment D – Transformation Grid.

I would also like to share with you separately a copy of a report published by the Association in March of this year, "How Kansas Stacks Up: A Regional and National Comparison of Mental Health Care Services." This document will give you some sense of how Kansas compares to its surrounding States concerning the public mental health system.

Kaiser Commission and Medicaid Spending

In May of this year, the Kaiser Commission issued a report examining Medicaid enrollment and spending trends. There are several interesting highlights from that report that are noteworthy:

- ✓ During a period from 2000 to 2004, Medicaid spending rose by 12% annually between 2000 and 2002, and then slowed to 7.6% from 2002 to 2004 as the economy improved following the 2001 recession. During this period of Medicaid enrollment growth, states were able to keep increases in health spending per Medicaid enrollee to levels below private insurance. Annual spending growth on medical services fell from 12.9% between 2000 and 2002 to 7.4% in the latest year.
- ✓ Spending per enrollee increased at an average annual rate of 5.2% for the aged and disabled and 5.9% for families from 2000 to 2004.
- ✓ Spending per enrollee grew at an average annual rate of 6.4% for acute care and 4.2% for long term care from 2000 to 2004. Notably, the per-enrollee acute care Medicaid spending growth was well below both the estimated 9.5% average annual increase in health spending for those with private coverage. During the same period, private insurance premiums rose by an average of 12.2%.
- ✓ Increased enrollment was responsible for much of the growth in Medicaid spending from 2000 to 2004. Medicaid enrollment grew primarily due to economic conditions that left more people eligible for the program as their incomes declined and many lost employer sponsored insurance coverage.
- ✓ It is difficult to imagine how Medicaid could have better controlled per capita spending, especially given that Medicaid purchases services in the same market as private insurance plans and kept per enrollee spending growth to levels below those seen in the private market.
- ✓ Approaches to contain costs that impose reductions on eligibility and enrollment or further limit provider payments are likely to lead to both greater increases in the number of uninsured and access to care barriers for Medicaid's low income population.

Comprehensive Neuroscience Project

We support the Comprehensive Neuroscience Project which is a partnership between SRS and Medicaid to review prescribing practices for Medicaid beneficiaries who receive behavioral health medications. The objective is to identify prescribing patterns of physicians outside the national standard guidelines and educating them through a variety of communication media. All changes on the part of the prescribing physician are voluntary. Targeted education and consultation will allow physicians to self-regulate their own prescribing practices once they become fully aware of best-practice standards. This program has been implemented successfully in Missouri and we look forward to enjoying similar successes here in Kansas.

Medicaid State Plan Rewrite

As you know, SRS and Medicaid staff have been working on addressing critical parts of the State's Medicaid Plan requiring revisions to meet the satisfaction of the Centers for Medicare and Medicaid Services (CMS). We support the approach taken and appreciate the recognition by SRS and Medicaid of the value in having the CMHCs retain primary responsibility for meeting

the needs of all Kansans accessing the public mental health system. Some of the benefits to this approach include:

- ✓ It is consistent with the values that have guided system partners in developing sturdy community-based services;
- ✓ Preserves current system infrastructures;
- ✓ Develops an integrated and coordinated portal to the public mental health system
- ✓ Increases access to Medicaid for qualified providers through associate agreements
- ✓ It enables the public mental health system is make effective and efficient use of all treatment resources available; and
- ✓ Collaboratively builds the future service system that supports core values of consumer choice and provider access in managed and cost effective ways.

There is much more that could be said about this approach and changes that will impact the public mental health system. However, our message to you today is that we support the approach and look forward to working with SRS, Medicaid and others in the various and multiple opportunities for feedback around implementation along the way.

KHPA Retreat

As part of your retreat this year, you identified planning domains, such as access and coverage, quality and safety, affordability and efficiency, and prevention and health promotion. We believe all of those planning domains are excellent domains to focus on for the future.

You indicated that meaningful health insurance coverage is a powerful indicator of financial access to care. We would ask that as you explore this issue, you include mental health benefits in those discussions. We believe true mental health parity (equal insurance coverage for mental illnesses on par with physical conditions) or at least increased incentives to improve employee benefits for mental health coverage would reduce the possibility of individuals having to rely on Medicaid insurance should they suffer from a mental illness that requires ongoing treatment where insurance does not provide coverage.

With respect to Goal 3 of the access and coverage domain, which is to stabilize and enhance the health care safety net, you emphasized the importance of stabilizing and enhancing the health care safety net which provides care to Kansans with low incomes or those without insurance. We would ask that you include in your considerations Community Mental Health Centers, as they are the safety net for individuals with low incomes and/or those without insurance who seek mental health care.

We support your quality and safety goal #1 which is to use data to drive policy development. Often times we find that policy makers and others rely on anecdotal information to make policy decisions or to influence policy making. We believe there should be an appropriate and effective use and dissemination of health data on which policy decisions can be made.

World Health Organization

It seems appropriate to mention here that The World Health Organization (WHO) estimates the burden of mental disorders will grow in the coming decades. They estimate that by 2020, mental disorders are likely to account for 15 percent of disability-adjusted life-years lost. Depression is

expected to become the second most important cause of disability in the world.

We know that treatment works and people can recover from mental illness. We know that psychosocial rehabilitation and family/group interventions in combination with medication can reduce the relapse rates for schizophrenia from 50 percent to 10 percent. We also know that the costs of not treating mental disorders outweigh the costs of treating them.

According to the WHO, there are evidenced-based social, environmental and economic determinants of mental health (see Attachment C). The WHO also goes on to say that individual and family-related risk and protective factors can be biological, emotional, cognitive, behavioral, interpersonal or related to the family context. For example, child abuse and parental mental illness during infancy and early childhood can lead to depression and anxiety later in life as well in next generations. Marital discord can precede conduct problems in children, depression among women and alcohol-related problems in
both parents. Elderly people who are physically ill may suffer from a range of subsequent risk factors and problems such as chronic insomnia, alcohol problems, elder abuse, personal loss and bereavement.

Also noted by the WHO are main evidence-based factors that have been found to be related to the onset of mental disorders. Those are also outlined in Attachment C.

The determinants of mental health and those risk factors identified as being related to the onset of mental disorders are things we as a state should continue to pay attention to and focus on in the years to come. I am happy to say that much of what the CMHCs do on a daily basis addresses many of these determinants and risk factors.

Exploring Opportunities for Medicaid Reform

We believe that Medicaid should continue to be the safety net health care program for the most disabled and vulnerable citizens. Medicaid must maintain a robust set of both mandatory and "optional" services to meet the full range of needs of the most disabled and vulnerable. Medicaid services should include an array of supports and services needed to maintain disabled and vulnerable populations within their communities and to avoid over utilization of costly institutional care. We also believe there are some opportunities worthy of consideration:

- Inspector General. We support the concept of an Inspector General for the Medicaid program in Kansas to protect the integrity of Medicaid programs and to have a concerted focus on Medicaid fraud and abuse. We believe this is an important and critical first step in any reform effort in Kansas. We must first ensure the integrity of current programs and eliminate opportunities for fraud before considering cost saving measures such as limiting benefits, restricting eligibility, etc.

- Mental Health Parity and Impact of Mental Health Treatment on Health Care Costs. We believe true mental health parity (equal insurance coverage for mental illnesses on par with physical conditions) or at least increased incentives to improve employee benefits for mental health coverage would reduce the possibility of individuals having to rely on Medicaid insurance should they suffer from a mental illness that requires ongoing treatment where insurance does not provide coverage. Research also shows that there is a decrease in total

health care costs following mental health interventions, even when the cost of the intervention is included. For example, a three year study by Aetna showed that the medical costs per beneficiary dropped from $242 per person to $162 in a period of three years after the introduction of mental health services.

- Evidence-Based Practices. We support working with Medicaid to appropriately incentivise the use of evidence-based practices. According to the Institute of Medicine, the lag between discovering effective forms of treatment and incorporating them into routine patient care is unnecessarily long, lasting between 15 and 20 years. With appropriate incentives, we believe that gap can be reduced. With the emergence of EBPs, the CMHCs are committed to a new level of quality and accountability in services and programs. We are implementing the following EBPs: Dartmouth Supported Employment; Dual Diagnosis Integrated Treatment; and Emerging Best Practice of Strengths Based Case Management.

- Expanded Role of Nursing Facilities for Mental Health (NFMHs). We believe there are opportunities to work with NFMHs to supplement acute care psychiatric inpatient resources which would reduce reliance on more costly inpatient care.

- Greater focus on Older Adults. We believe with appropriate funding identified for mental health outreach to older adults, those efforts could lead to reducing the premature admissions to nursing facilities, thus saving Medicaid expenditures for long-term care. Research shows that almost 20% of persons age 55 and over experience specific mental and cognitive disorders that are not part of the "normal" aging process. Research also shows that older adults with any diagnosed mental illness are about twice as likely to have to move to a higher level of care.

- Encourage Flexibility and Innovation. We believe State Medicaid regulations should be designed in such a manner as to minimize unnecessary administrative costs and encourage innovation and flexibility so as to provide quality, cost effective services in the most efficient manner possible.

Other ideas include:

- Eliminating errors, overuse, rework, inefficient processes and duplication will increase quality and decrease costs.
- Employer mandates and providing financial assistance to workers and employers to afford coverage.
- Pool purchasing power to make coverage more affordable.
- Allowing buy ins for workers.
- Promoting use of health information technology.
- Emphasizing and paying for prevention and early intervention.
- Demonstration projects that reward Medicaid clients for making healthy lifestyle choices and create incentives to be more prudent health care consumers.

Transformation of the Public Mental Health System in Kansas

It is important to note that reform themes in overall health system, such as care coordination, information technology, pay for performance and consumer-driven care are themes that are

encompassed in transformation themes currently underway in the Kansas public mental health system.

By Executive Order of Governor Sebelius, Executive Order No. 04-10, issued on September 22, 2004, the Governor's Mental Health Services Planning Council (GMHSPC) is directed to coordinate New Freedom Commission-related recommendations from stakeholders, consumers, mental health service providers, community services providers and others, and based thereon, make appropriate recommendations to the Governor; and to work with the State Mental Health Authority; as well as other State departments, to improve and refine the State's mental health strategic plan and develop strategies to improve mental health services across all systems and State departments.

Pursuant to the Executive Order, the Transformation Subcommittee (TSC) of the Governor's Mental Health Services Planning Council was created. Dr. Jane Adams, Executive Director of Keys for Networking and also a Commissioner on the President's New Freedom Commission; and Mike Hammond, Executive Director of the Association of Community Mental Health Centers of Kansas, Inc, serve as the Co-Chairs of this Subcommittee. The primary work product of the TSC has been the development and continual adopting of a Transformation Grid consisting of themes and tasks (see Attachment D). This Grid has been presented to the GMHSPC Subcommittees to move these themes and tasks from the Grid into their respective work. It is an action agenda in progress.

Concerns Moving Forward

- We are concerned about the impact of Presumptive Disability on the mentally ill who are currently receiving services through the MediKan program. As you know, if a MediKan client is not presumed disabled through the review process and have exhausted all Social Security Administration appeals, they will no longer receive medical benefits. That leaves those MediKan clients currently served by the CMHCs without any resources. Due to a current state mandate that CMHCs serve everyone who walks through our doors, this means additional strain on already strained resources. This is a concern shared by key legislators and those concerns were voiced during the 2006 Legislature. We hope there will be opportunities this summer and fall to work with the Authority staff to examine viable options so that resources are made available to address this concern.

- We are concerned about the impact of the Deficit Reduction Act (DRA) on the citizens of Kansas who rely on Medicaid. The DRA provisions either require mandatory changes in state Medicaid programs or add to the myriad of options already available to states in the Administration of their programs. We have not heard from Medicaid as to the outcome of their process in evaluating those provisions and what impact those will have on Kansas.

- We are concerned about employer insurance coverage eroding; personal incomes continue to shift downward; the impact of Medicaid changes at the federal level; rising insurance premiums; and limited resources. An equally important concern we share with others is that there is no consensus on reform strategies.

- We do understand that the legislative timeline of January 2007 is a point in which the KHPA could make a decision about including or excluding Home and Community-Based Services

(HCBS), Targeted Case Management (TCM), Mental Health, Nursing Facilities for the Mental Health (NFMHs), Nursing Facilities (NFs), Substance Abuse (SA), and State Hospitals under the KHPA. If all were to move, it would mean an additional $1.1 billion in expenditures overseen by the KHPA. Because the KHPA assumed those programs under the direction of the Division of Health Policy and Finance (DHPF) effective July 1, 2006, which includes Medicaid, we believe the January 2007 timeline for considering other programs under the KHPA is too ambitious. We believe the challenges of the current programs under the authority of the KHPA are challenges that will warrant significant time of the Authority and its resources that assuming any new programs would not serve the best interest of those programs, the consumers and families impacted or providers. Therefore, we are recommending that the KHPA request to the 2007 Legislature a delay in any considerations of expansion until at least January 2008. As of today, both the Association and the Transformation Subcommittee do not support moving mental health from SRS to the KHPA.

Whatever direction you take in forging forward with your responsibilities to reform health care in Kansas, we urge you to make sure it is a collaborative effort that includes: State agencies, the public, employers, insurers, providers, advocates, pharmaceutical companies, and most importantly, the consumers of services.

Thank you for the opportunity to appear before you today.